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Commentary

Who contracts for primary care?

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Summary

The implications of the 1997 NHS (Primary Care) Act have been largely overlooked in the rush to establish Primary Care Groups. Allowing health authorities to develop local contracts for primary care has far-reaching implications and is an important departure from the national system of negotiation that has characterized general practice to date. This paper describes a content analysis of a sample of Personal Medical Services (PMS) pilot contracts. In the first year little attention has been given to achieving cost savings or greater efficiency and few contracts promote clinical guidelines. The difficulties of specifying services sensitive to local health needs are highlighted and the national Statement of Fees and Allowances (the 'Red Book') may not be swiftly supplanted. However, the pilots have introduced innovations such as salaried general practitioners, nurse-led services and NHS trust-managed care. The development of local contracts provides a valuable learning experience for general practitioners and health authorities in advance of the establishment of Primary Care Trusts.

Keywords: PMS pilots, primary care, contracts

Introduction

In 1996 the Conservative government carried out a 'listening exercise', asking primary care professionals their views of the prevailing arrangements for providing primary care services. Some respondents to the consultation suggested that general practitioners (GPs) should have available the option of salaried employment and that there should be greater local discretion to shape services to meet particular patient needs.[1] This outcome implied that the key hallmarks of the British system of general practice – the independent contractor status of GPs and the national nature of the GP contract – no longer enjoyed unqualified support among the profession.

The NHS (Primary Care) Act of 1997 gave GPs and health authorities (HAs) discretion to make service agreements similar to those made between HAs and NHS trusts since 1991. It heralded the introduction of a local contract for primary care and permitted HAs, NHS trusts and general practices to employ GPs on a salaried basis. Both changes are being piloted on a voluntary basis and the first wave of so-called Personal Medical Services (PMS) pilots began in April 1998. Under PMS, providers are regulated by Part One of the 1977 NHS Act rather than Part Two, which continues to guide General Medical Services (GMS). Resources for PMS form a cash-limited budget held by the local health authority.

PMS contracts are of two main kinds – those providing basic personal medical services similar to traditional GMS ('PMS pilots') and those providing, in addition, other services beyond the normal remit of GMS, such as community nursing ('PMS Plus pilots'). Although a regulatory framework has been imposed on PMS pilots, which ensures that the local contracts share some similarities with the GMS contract,[2] HAs and pilot sites are free to develop innovative approaches to meeting patient needs.

The change of government in 1997 altered the policy context considerably. The incoming Labour government retained the Act but introduced new policy objectives against which the 82 operational pilots are to be evaluated.[2] These policy objectives include: 'fairness' (addressing areas of poor quality and improving access for the disadvantaged), 'efficiency' (maximizing health outcomes per unit of resource), 'effectiveness' (appropriate and evidence-based care), 'responsiveness' (meeting identified patient needs and taking account of patient preferences), 'integration' (enhanced team working and intersector collaboration), 'flexibility' (new working relationships, organizational forms and employment arrangements), and 'accountability' (to local communities and to health authorities).

The NHS Executive (NHSE) evidently intends the PMS experiments to benefit patients through the provision of high-quality, needs-sensitive and appropriate services that co-ordinate the many agencies and professionals acting in primary care. The NHS is expected to benefit from greater levels of public accountability and higher levels of cost effectiveness. PMS pilots are also expected to benefit primary care

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professionals by providing new, more flexible, opportunities for employment, thereby improving the recruitment, retention and skills of primary care professionals.

In theory, contracts are mechanisms through which an agent – the PMS site – agrees to provide services on behalf of the principal – the health authority.[3] Contracts themselves are binding agreements and the agent is required to deliver the services specified. Contracts may also introduce financial incentives, such as linking some of the payment to performance or stipulating guidelines to be followed. Contracts are, therefore, potentially important levers for change and, by focusing the contracting parties on their objectives and the methods for implementing them, policy goals can be achieved.

The aim of this study was to consider the extent to which the negotiation of contracts directly between health authorities and local providers is likely to contribute to the achievement of the policy aims of the Primary Care Act. The content of the PMS pilot service agreements (i.e. contract) should provide prima facie evidence of how far this has occurred. We describe a content analysis of the service agreements arising from nine PMS pilot sites selected to form a demonstration network run by the National Primary Care Research and Development Centre (NPCRDC) and the King's Fund (KF).

Methods

Service agreements were requested from the nine sites and eight were received. They represent approximately 10 per cent of the pilots that have gone 'live'. In light of the heterogeneous nature of the national group of pilots, a purposive, maximum-variation sampling approach was adopted. This ensured that the main types of pilot were included in the sample – both PMS and PMS Plus pilots with a full range of potential pilot characteristics such as the inclusion of salaried and independently contracted GPs and nurse practitioners. Pilots are managed by either GP organizations or NHS trusts (see Table 1). The sample was also selected on the basis that they had clear aims and had demonstrated organizational ability. Their service agreements should therefore certainly be no less sophisticated than those of other PMS pilots.

Criteria to identify and measure the achievement of each policy aim were drawn up by the research team. A content analysis of each service agreement was carried out and recorded by each team member working independently with these criteria. Findings were pooled and validated at a single meeting. Service agreements were examined in isolation from any other written material or policies that may have existed alongside them, such as the pilot application document. Contracts are also 'embedded' in unwritten social relationships between the health authority and the pilot. These relationships are not mentioned in the contracts but supplement the incentives, controls and data flows, which are. The service agreements themselves may not fully describe the ways in which the pilots intend to meet the NHSE policy objectives outlined above. In addition, what is written into service agreements may not necessarily be translated into action. However, service agreements do represent firm intentions, which the provider is contractually obliged to carry out.

Results

The service agreements specified a number of general objectives that were consistent with the policy themes identified by the NHSE. Most commonly referred to was the objective to enhance equity of service provision (five sites) especially in relation to particular groups within the population held to be currently disadvantaged. Other objectives included the provision of high-quality care (five sites), greater efficiency (four sites) and more clinically effective services (four sites). Objectives mentioned less frequently were those to enhance professional development, better meet local or individual needs, involvement of the community and better interagency collaboration.

Although service agreements referred to this wide range of high-level objectives, they did so in terms of broad aspirations. Service agreements also identified more concrete proposals that would further the seven key NHSE objectives. These are shown in Table 2.

The objective of promoting greater equity was exclusively addressed through targeting specific population groups felt to be disadvantaged in terms of access to services. With the exception of one site, agreements did not make clear whether these groups had been selected using a formal process of needs assessment.

In terms of the 'efficiency' objective, there was little evidence of any service changes that would result in reduced costs, or greater outputs or health gain for a given cost. Nor was there significant evidence of performance incentives or penalties as part of the service agreement.

The 'effectiveness' objective could be evidenced by the incorporation of local or national clinical guidelines and outcome measures into the service agreements. However, only three sites had included guidelines (although two sites indicated that they would do so within the lifetime of the pilot) and outcome measures broadly replicated those included within GMS.

Terms within the service agreements relating to 'responsiveness' were still harder to detect, and there was overlap with the intention to improve equity by targeting particular client groups. Nevertheless, a limited range of initiatives to ensure sensitivity to patient needs was identified.

The 'integration' objective has, in part, been served through the very establishment of PMS Plus pilots. For example, where community trusts have formed pilots, there has been an increase in the level of integration between existing staff and their

Table 1 Organizational characteristics and key objectives of NPCRDC-KF demonstration sites

Site	Contract type	Organizational features	Key objectives
Pilot 1	PMS+	New practice managed by community NHS Trust employing salaried GPs	Reduce health inequalities Inter-sectoral collaboration Promote access to primary care for disadvantaged groups
Pilot 2	PMS	New practice managed by community NHS Trust providing a 'nurse-led' service and employing salaried GPs	Nurse-led service Focus on evidence-based practice and public health Meet the needs of disadvantaged groups
Pilot 3	PMS	Practice-based pilot networking one group and two single-handed practices and offering GPs a salaried option	More flexible access for patients Better GP recruitment Service development for the elderly
Pilot 4	PMS+	New practice providing 'nurse-led' services with support of salaried GP	Nurse-led service Extended services to include complementary therapy and social welfare advice
Pilot 5	PMS+	Practice-based pilot networking eight group practices with an overarching management function	New models of care delivery Integrated pathways for chronic disease management Improved services for the mentally ill and the elderly Greater use of intermediate care
Pilot 6	PMS+	Practice-based pilot networking eight group practices with an overarching management function; salaried option offered	Improve the range and quality of services Improve equity and access to services Multi-sectoral collaboration More efficient and effective use of resources
Pilot 7	PMS+	Integration of two practices within primary care directorate of NHS Trust as salaried practitioners	Inter-sectoral collaboration Promote access for disadvantaged groups Attract and retain high-quality staff
Pilot 8	PMS+	New practice to serve new town development, managed as separate unit within community trust and employing salaried practitioners	Meet needs of new and expanding population Focus on effectiveness, appropriateness and quality Inter-sectoral collaboration and partnership with users Public health approach
Pilot 9	PMS	Integration of existing small practices into new directorate of community trust, offering salaried employment and central management function; also providing new practice in under-doctored area	Maintain and improve primary care by establishing a salaried GP option

new, salaried GPs. Similarly, the introduction of NHS trusts as providers of personal medical services is itself an indication of 'flexibility'. However, the most significant ways in which service agreements promoted 'flexibility' were through the introduction of salaried employment for GPs and two types of 'nurse-led' primary care (an 'independent contractor' model and a 'trust-employed' model).

'Accountability' was addressed through a range of structural mechanisms that were incorporated within the service agreements. The most innovative form of accountability was a charter between the pilot and the local Community Health Councils (CHCs) that gave CHC members the right to visit pilot premises and provide reports to the pilot and the health authority on their findings.

Discussion

It is very early in the process of introducing local service agreements within primary care, and this research can only begin to assess their development. More research will be needed as the contracting process matures, and a national programme of evaluation is currently under way, which will supplement local evaluations carried out by the pilot sites themselves. This small study provides insight into the results of local contracting in primary care and suggests that PMS pilots have the intention to fulfil, at least in part, the policy objectives for which they were introduced. However, local service agreements were surprisingly limited in key areas.

Although 'value for money' is a key criterion for judging

Table 2 Contract characteristics consistent with NHSE PMS pilot policy objectives (numbers in parentheses relate to number of pilot sites)

Equity	Efficiency	Effectiveness	Responsiveness
Targeted population sub-group: • Homeless (3) • Mentally ill (3)	Contract type: • Block (4) • 'Red Book' (2) • Fee for service (1)	Clinical guidelines: • Incorporated into contract (3) • Planned (2)	Service review process (1) User survey (1) Homeless persons protocol (1)
Other groups: Refugees, temporary residents, chronic disease, ethnic minorities	Performance-related incentives (1)	Diseases covered by guidelines: • Ischaemic heart disease (3) • Diabetes (2) • Asthma (2) • Cholesterol (2) • Five other diseases Outcome measures: • Vaccination and immunization (6) • Cervical cancer screening (6) • Prescribing (2) • Asthma peak flow (1)	Service review to cover racism, cultural sensitivity and needs of disabled (1)

success, contractual mechanisms to achieve cost savings, more efficient productivity or performance incentives are virtually absent. It would appear that service development in areas of mutual concern to pilots and their health authorities, rather than financial efficiency, has driven the local agreement process. This raises the question of how effective local service agreements will be in achieving change in areas where conflicts of interest between health authority and provider may exist.

'Accountability' was apparently taken to mean accountability to the health authority for fulfilling the terms of the agreement and ensuring financial probity. This is a managerial rather than a 'consumerist' conception of accountability.[4] Despite strong encouragement from the NHSE, there were few structured attempts to increase the level of patient participation. Although service agreements referred to information booklets (in accordance with PMS pilot guidance) this would represent the most passive form of participation.[5] However, user panels proposed by two pilots, one of which would also involve local elected political representatives, and the formal links developed with the CHC by another suggest that new opportunities for user involvement may be developed in a minority of cases.

There were few attempts to incorporate clinical outcomes into service agreements but this may reflect the lack of progress in this area nationally rather than a failure of PMS pilots. The paucity of quantified outcome measures in these service agreements reflects both the technical difficulty of linking outcomes to process and a reluctance to be held to account for health consequences that may be beyond the clinicians' control.

Clinical guidelines may become more prominent as the mechanisms of clinical governance in primary care take shape. The National Institute for Clinical Excellence will produce guidance and standards for clinicians that are likely to feature in future service agreements.[6] However, this might suggest that health authorities and Primary Care Groups will be more able to ensure compliance with national standards from pilots than from other general practices. This degree of apparent centralism sits uneasily with the 'bottom-up' rhetoric that was present at their birth. The limited evidence of formal needs assessment was unsurprising. Fundholders and those involved in Total Purchasing pilots similarly showed limited interest in needs assessment.[7]

The workload involved in developing local service agreements should not be underestimated. The capacity of health authorities to manage this process is limited. Two PMS pilot agreements were not signed off within the first half of the year, reflecting the complexity of establishing pilot arrangements and the level of negotiation involved. This may affect the sustainability of PMS pilots and their extension beyond pilot status. In theory, there are two extreme variations of contract: those that specify every possible outcome or action of the agent but with high transaction costs; and those contracts that vaguely define responsibilities but at low negotiation costs.[8] Early experience suggests that PMS pilots have adopted the latter approach.

These agreements were the first of their kind and represented a leap of faith by the providers (and, to a lesser extent, the health authorities). By not forcing revolution or major cost savings in the first year a more successful evolution of local contracting may have been secured. PMS pilot participants are volunteers, with most GPs clutching a 'return ticket'. A negotiated settlement that threatened income and too much organizational change may well have been abandoned.

These contracts provide a starting point and may become more sophisticated over time. Importantly, the Primary Care Act has brought community trusts into the primary care market. They have a good opportunity to demonstrate that they can provide high-quality care in areas where traditional forms of

Table 2 Continued

Integration	Flexibility	Accountability
Integration via NHS Trust management of pilot (4) Employment of liaison staff (3) Integrated records (2) Shared care maternity (1)	Salaried GPs (6) Provision of PMS by NHS Trusts (5) 'Nurse-led' services (2)	New monitoring framework (4) Patient information booklet (3) Formal project board (2) Public business plan (2) User panel (2) Charter agreed with CHC (1)

primary care have signally failed. Primary Care Trusts (PCTs) will emerge from the integration of Primary Care Groups and community trusts. PMS pilots can be part of this metamorphosis for community trusts. Similarly, PMS pilots provide early experience for health authorities and GPs of specifying primary care services in advance of the formal establishment of PCTs.

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